ROB BONTA
Attorney General of California
GREG CHAMBERS
Supervising Deputy Attorney General
State Bar No. 237509
THOMAS OSTLY
Deputy Attorney General
State Bar No. 209234
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3871
Facsimile: (415) 703-5480
E-mail: Thomas.Ostly@doj.ca.gov
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **Rowena Gail Garcia-Chuapoco, M.D.** 1860 El Camino Real Suite 101 Burlingame, CA 94010-3106 Physician's and Surgeon's Certificate No. A 51290, Respondent.	Case No. 800-2017-033549 **FIRST AMENDED ACCUSATION**

1. Reji Varghese (Complainant) brings this First Amended Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On October 20, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number A 51290 to Rowena Gail Garcia-Chuapoco, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2024, unless renewed.

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JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in pertinent part, that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

6. Section 2266 of the Code provides that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Inaccurate and Inadequate Medical Records)

8. Respondent is Board Certified in Internal Medicine and specializes in Gastroenterology. In February 2017, 66-year-old Patient 1 was referred to Respondent for

evaluation of changes in her bowel habits. Respondent conducted an appropriate patient history and workup, and recommended Patient 1 undergo a colonoscopy.

9. Respondent performed a colonoscopy on February 14, 2017, at an outpatient ambulatory surgery center owned and operated by Respondent's medical practice. A patient examination was performed by nursing staff prior to the procedure. Patient 1's preoperative vital signs were within normal range, with blood pressure of 111/60, heart rate of 66, and oxygen saturation of 100%.

10. The colonoscopy was performed under moderate, conscious sedation, which was administered by a Registered Nurse, who was under Respondent's immediate supervision. The procedure was performed with continuous pulse oximetry and blood pressure monitoring, and with the administration of supplemental oxygen. At 10:54 a.m. the nurse sedated Patient 1 with intravenous Versed 2 mg, and Demerol 50 mg, and the procedure commenced at 10:59 a.m. Over the course of the 21 minute procedure, Patient 1's vital signs changed significantly. Her blood pressure increased, at one time recorded as high as 198/124, and her heart rate became elevated. Patient 1's oxygen saturation at 11:11 a.m., twelve minutes into the procedure, was recorded at 39%; by 11:21 a.m., when the procedure concluded, it was at 38%. Respondent stated during her Board interview that she was unaware of the changes in Patient 1's vital signs, although they were visible on a monitor positioned so that Respondent could see it. Respondent also stated that additional sedative medication was administered by the Registered Nurse during the procedure, without her consent or knowledge. However, the Colonoscopy Report, written by Respondent immediately after the conclusion of the procedure, documents administration of a total of 100 mg Demerol, 4 mg Versed and 50 mg of Benadryl, reflecting the additional medication administered during the procedure.

11. At approximately 11:23 a.m., Patient 1 was difficult to wake after the colonoscopy. Within minutes, as the patient continued to deteriorate, resuscitation efforts were initiated, including administration of the reversal agent Narcan, oxygen and placement of an airway. Patient 1 was bradycardic, her vitals were fluctuating, and blood pressure dropped. Advanced cardiovascular life support protocol was initiated, and 911 was called. Responding paramedics

transported Patient 1 to the nearby hospital, where she died after several days on life support.

12. Respondent's Colonoscopy Report[1] states that sedation was administered by the nurse, under Respondent's immediate supervision, and that continuous pulse oximetry and blood pressure monitoring were maintained throughout the procedure. The report documents Patient 1's tolerance of the procedure as "excellent", describes the procedure as "not difficult" and notes there were "no apparent limitations or complications." The Colonoscopy Report does not reflect Patient 1's fluctuating vital signs and contains no mention of Respondent's assertion that additional sedation was administered by the nurse without her knowledge or consent. The medical record of the resuscitation efforts contains only sparse information, and does not include Patient 1's oxygen saturation during that period. An Incident Report, which Respondent states she prepared on February 14, 2017, states "Patient was stable during the procedure with stable vital signs and no signs of distress."

13. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Sections 2234 and/or 2234(b) and/or 2234(c) and/or 2266 of the Code based upon gross negligence and/or repeated negligent acts and/or failure to maintain accurate and adequate records, including but not limited to the following:

A. Respondent failed to appreciate, recognize or respond to Patient 1's deteriorating condition during the colonoscopy. Patient 1's vital signs indicated she was having difficulty, with evidence of intolerance. Patient 1's heart rate and blood pressure became elevated, even after administration of additional sedation. Respondent did not respond to Patient 1's changed vital signs, including a significant drop in oxygen saturation, by assessing or responding to the Patient 1's clinical status.

B. Respondent failed to establish and maintain a line of communication with the Registered Nurse who administered sedation, and failed to take steps to ensure she was aware of Patient 1's condition over the course of the procedure. While Respondent

[1] The medical record contains two Colonoscopy Reports, both authored by Respondent, for the February 14, 2017 colonoscopy. The reports are for the most part the same, but differ slightly. The record contains no explanation for the two separate reports. During her Board interview, Respondent explained that the procedure report is a 'template' and that she created the second report to reflect that no discharge instructions were given to Patient 1.

documented that Patient 1's sedation was administered under her "immediate supervision," she failed to ensure that the sedation was properly administered, to assess the patient over the course of the procedure or even to look at the monitor.

C. Respondent failed to respond promptly to evidence of Patient 1's distress during the procedure. Respondent's failure to recognize, appreciate and respond to the significant clinical deterioration resulted in a delay in responding to the patient's distress. There is no indication in the chart, or in Respondent's account to the Board's investigator, that she took steps to assess Patient 1 at the conclusion of the procedure, even though her Colonoscopy Report makes it clear that she was fully aware of the total amount of sedation administered.

D. Respondent's medical record is incomplete and inaccurate. Respondent created two separate Colonoscopy Reports, without documenting a late entry or explaining why there were two reports. Respondent's Colonoscopy Report documents that the colonoscopy was uneventful, that the Patient 1's tolerance of the procedure was "excellent" and there were no limitations or complications, when in fact, Patient 1's clinical condition deteriorated significantly and the data that was readily available to Respondent reflected abnormal and alarming changes in Patient 1's vital signs during the colonoscopy. Respondent failed to accurately or completely record the resuscitation efforts, and in particular, did not document Patient 1's oxygen saturation during this period. Respondent's Incident Report inaccurately states that Patient 1 was stable during the procedure, with stable vital signs and no signs of distress.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 51290, issued to respondent Rowena Gail Garcia-Chuapoco, M.D.;

2. Revoking, suspending or denying approval of respondent Rowena Gail Garcia-Chuapoco, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering respondent Rowena Gail Garcia-Chuapoco, M.D., to pay the Board the costs of the investigation and enforcement of this and, if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: FEB 23 2023

REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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